

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/26/2011	
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00093887.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 17, 2011.</p> <p>Complaint IN00093887 - Substantiated. Federal/state deficiencies related to the allegations are cited at F-312.</p> <p>Survey dates: July 25, 26, 2011</p> <p>Facility number: 000028 Provider number: 155070 Aim number: 100275370</p> <p>Survey team: Donna Groan, RN, TC Avona Connell, RN Gloria Reisert, MSW Dorothy Navetta, RN</p> <p>Census bed type: SNF/NF: 113 Total: 113</p> <p>Census payor type: Medicare: 8 Medicaid: 86 Other: 19</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0312 SS=D	<p>Total: 113</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/27/11 by Suzanne Williams, RN A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review, observation and interview, the facility failed to ensure a dependent resident was assisted with washing of a contracted hand. This deficient practice affected 1 of 5 residents reviewed with hand contractures in the sample of 5. (Resident D)</p> <p>Findings include:</p> <p>Resident D was observed seated in an upright chair on 7/25/11 at 8:05 a.m. Both hands were contracted. RN #1 was at the nurse station and was asked to assess the resident's hands. The right hand had very little movement, and no crusting nor odor was detected. When RN #1 checked the resident's left hand, she made a circular motion with her index finger between the palm of the resident's hand and fingers. RN #1 indicated there was scaliness and a foul odor was noted.</p>			F0312	<p>1. Immediately following notification of the alleged finding, Resident D's left hand was assessed for any skin or care concerns. No skin or care concerns were noted. There was also no foul odor or scaliness noted. Upon interview with the CNA assigned to the resident's care at that time, the associate stated she had not yet been able to provide the resident her hand contracture care for that shift. The reason being that the associates had been busy doing their morning round, getting residents up for breakfast and then providing assistance to those who need assistance with dining. Additionally upon interview with RN#1, she denies having indicated that there was any odor to the resident's left hand. Upon interview with the Occupational Therapist, he stated that the only times he had ever noticed any type of odor coming from the</p>		08/08/2011

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	<p>The odor was noticed from a distance of two feet from the resident.</p> <p>Clinical record for Resident D was reviewed on 7/25/11 at 9:17 a.m. The resident's diagnoses included, but were not limited to, Parkinson disease and paralysis agitans. The current Care Plan, dated 2/28/11, included, but was not limited to: Problem Onset: 03/07/11 "I need extensive to total assist to complete ADLs (Activities of Daily Living) r/t (related to) increase in tremors, confusion, and weakness; risk for functional decline; Approaches: Assist me with all ADLs, encourage me to participate as able."</p> <p>The most recent Significant Change MDS (Minimum Data Set) Assessment dated 3/9/11 indicated resident D required assistance of two or more staff with hygiene and bathing.</p> <p>During interview on 7/25/11 at 9:55 a.m., with the Occupational Therapist, he indicated they use soft rolls for the contractures of the resident's hands and has noticed a smell from the hands once or twice.</p> <p>This federal tag relates to Complaint IN00093887.</p> <p>3.1-38(a)(2)</p>				<p>resident's hand was prior to the resident having received hand contracture care for that shift. Finally, upon interview with the resident's family member who visits the resident on a daily basis and usually several times a day. She states she has never noticed any odor or scaliness to her mother's hands. 2. Residents with closed hand contractures have the potential to be affected by the alleged deficient practice. An audit was completed on 7/27/2011 by the D.O.N. for residents with closed hand contractures. The audit revealed that all hands were clean and free of any odor or scaliness. 3. On 8/1/2011 nursing staff were inserviced on hand contracture care by the SDC. 4. D.O.N. or designee will complete an audit of residents with closed hand contractures weekly x 4 weeks, then monthly for up to 1 year to ensure that residents with closed hand contractures have no odor or scaliness to the contracted hands unless otherwise medically contraindicated. Results from the audits will be reviewed monthly at the PI committee meeting for a minimum of 1 year to ensure 100% compliance. After 1 year, if 100% compliance has not been achieved, the audits will continue to be conducted monthly and reviewed monthly at the monthly PI committee meeting until 100% compliance has been achieved. Systems will be updated as</p>		

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	3.1-38(a)(3)(A)				indicated.		